Medicine as a Profession: A Hypothetical Imperative in Clinical Ethics

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I. INTRODUCTION

The ethical concept of medicine as a profession was introduced, I have argued, into the histories of medicine, medical ethics, and philosophy by two physician-ethicists, John Gregory (1724–1773) of Aberdeen and Edinburgh in Scotland and Thomas Percival (1740–1804) of Warrington and Manchester in England. This concept requires three commitments of physicians, all freely undertaken: to become and remain scientifically and clinically competent in patient care, research, and education; to make the protection and promotion of the health-related interests of patients (which interests are a function of the first commitment) the physician’s primary concern and motivation, with self-interest kept systematically secondary; and to maintaining, strengthening, and passing on medicine as a public trust, rather than self-interested merchant guild, to future generations of physicians and patients (McCullough, 1998, 2006, 2011). These three commitments provide the content for professional integrity in medicine and medical ethics. The first commitment defines the intellectual integrity of physicians, while the second and third together define the moral integrity of physicians.

The papers in this, the 2015 Clinical Ethics issue of the Journal, explicate or draw on these concepts in interesting and varied ways. In doing so, they mark a distinction from the tendency in much of contemporary bioethics to de-professionalize medical ethics and therefore medicine (McCullough, 2011). There is no categorical imperative for a medical profession, which is an invention of two remarkable 18th-century, Baconian physician-ethicists. Deeply rooted, respectively, in Humean moral science and the Scottish Enlightenment and in Rational Dissent and the English Enlightenment, Gregory and Percival would have no truck with Kantian philosophy because it was “speculative,” not a term of epistemological endearment in Baconian discourse. They aimed to
make medicine a profession worthy of the name, meriting the trust of the sick who were now patients under the protection of professional responsibility.

There is only a hypothetical imperative for medicine as a profession thus understood. There is no deliverance of reason on which to base professional clinical ethics, only the prudential choice not to return to the nonprofessional, contractual medical enterprise that dominated the history of Western medicine and medical ethics until Gregory and Percival changed the history of medical ethics. Lest the reader think that this history is of only antiquarian interest, Manea (2015) describes vividly how post-World War II Romania recreated the contractual medicine marked by deep distrust of physicians and medical institutions that Gregory and Percival set out to change. Manea’s paper and each of the following papers should, of course, be read independently and critically assessed by the reader on its own terms. Manea’s paper with its explicit appeal to professional integrity and the trust that it warrants and the other papers in this Clinical Ethics issue, each in its own way as I hope to show, can also be read as shedding light on the hypothetical imperative of medicine as a profession in clinical ethics.

II. MEDICINE AS A MORAL ENTERPRISE

Ssebunnya (2015) provides what he calls a “trifocal perspective on medicine as a moral enterprise” in response to the unraveling of the Hippocratic tradition in medicine and medical ethics. With an acknowledged debt to Pellegrino’s (2008a 2008b 2008c 2008d 2008e) philosophy of medicine, the proposed trifocal perspective comprises “moral agency,” “the moral imperative of the good physician,” and “an integrated action-guiding practical analytical framework” (Ssebunnya, 2015, 9). Ssebunnya seeks an “authentic philosophy of medicine” (Ssebunnya 2015) that takes seriously the limited perspective of specific approaches, characterized as “mono-focal viewpoints” (Ssebunnya, 2015, 10). An authentic philosophy of medicine, by contrast and as a corrective, will be rooted, as Pellegrino proposed, in the concrete reality of the physician–patient relationship. The word-order is, I think, crucial: In a professional medical ethics, the physician freely commits to the care of the sick, transforming them into patients protected by the physician’s freely undertaken commitment to care. Ssebunnya, responsive to skepticism about such comprehensive approaches, argues that, notwithstanding, the proposed approach meets criteria for theory construction. Ssebunnya draws on diverse philosophical resources in advancing his argument for the proposed trifocal approach. The work of St. Thomas Aquinas and Bernard Lonergan, infrequently invoked sources in contemporary clinical ethics, loom large in Ssebunnya’s exegesis.

One bedrock consideration becomes “the dignity of—and the prevention of indignity to—the patient as a human person” (Ssebunnya, 2015, 16),
which, in turn, becomes the basis for virtue-based action in clinical practice via sustained, deliberative clinical ethical judgment. The preservation of each patient's dignity and the prevention of assaults on it become important prudential reasons in favor of medical professionalism as a hypothetical imperative, based on the physician's freely undertaken commitment to professional responsibility to and for each patient.

III. BRIBERY AND MEDICAL PROFESSIONALISM

Manea (2015) addresses a major topic in clinical ethics in Eastern Europe during the period of subjugation to Soviet tyranny in the four decades after World War II: bribery of physicians as a social practice, with a focus on Romania. Manea frames her analysis in terms of trust. Bribery of medical practitioners can be interpreted as a response to lost trust in social practices and institutions, which medicine as a profession surely is. Manea puts forth an ethics of trust as an antidote. Bribery in the clinical setting differs from expressions of gratitude, which may be tendered unconditionally, in that the "gift" is offered by the patient and accepted by the physician "as a condition for the provision of health care, access to medical equipment, tests, procedures, or a certain quality of care" (Manea, 2015, 26-7). There is also what Manea calls "institutional bribery" that occurs between the pharmaceutical and device industries and physicians around the world. Unlike a tip for a waiter in a café or restaurant, the giving of something of value to a physician as a condition for clinical care that the physician should understand himself or herself to be obligated to provide as a matter of routine is not optional. As a matter of professionalism in medicine, this should not be the case, and medicine becomes a corrupt social institution to the extent that bribery exists. Manea explains the varied, substantive ethical objections to bribery. Manea's analysis takes a comprehensive perspective, including social factors such as low physician salaries that create an environment in which bribery is incentivized and then flourishes. Instead of becoming patients protected by the sustained commitment of physicians to professional responsibility, the sick risk becoming contractors with an untrustworthy, potentially predatory social institution, the members of which, physicians, regard the sick as the means to fulfillment of economic self-interest. The result is the corruption of the medical profession. Trust needs to be rebuilt, from the ground up, focusing, Manea proposes, on education.

The loss of trust in medicine as a social institution, as a profession worthy of the name, that Manea describes underscores the concept of medicine as a profession as a hypothetical imperative. A creature of reason, the categorical imperative of medicine as a profession, would be more durable, more resistant to the transition from optional gifts of gratitude to necessary gifts of bribery. Manea's call for education can be read as a call to re-create the
commitments of physicians to intellectual and moral integrity, the source of medical professionalism becoming a social reality and not a slogan met with warranted cynicism and mistrust.

IV. EPISTEMIC PRIVILEGE, EPISTEMIC AUTHORITY, AND PREGNANCY

Freeman (2015) explores the close connection between knowledge and agency and the “epistemic injustice” that occurs when one’s knowledge or belief claims are disrespected and a foundation of one’s agency thereby weakened. In this philosophical investigation, Freeman focuses on pregnant women. Epistemic injustice wrongs the pregnant woman by discounting her “capacity as a knower” (Freeman, 2015, 56). To capture the concept of epistemic injustice against pregnant woman, Freeman introduces “the phrase ‘panoptics of the womb,’” drawn from Foucault and used “to refer to the predominance of and reliance on a visual paradigm of knowledge within the domain of pregnancy, the normalized medical surveillance used within this domain, and the technologies on which such a visual paradigm depends” (Freeman, 2015, 45). Given the increasing use and sophistication of obstetric imaging—from 3D ultrasound to magnetic resonance imaging—a panoptics of the womb generates considerable epistemic power that, unless responsibly managed, can lead to paternalistic undermining of the pregnant woman’s autonomy in the form of diminished “epistemic privilege that pregnant women have over their bodies” and therefore commensurate “epistemic powerlessness” (Freeman, 2015, 46). Freeman argues that “understanding the body as Leib, not Körper [a distinction drawn from the work of Husserl, Merleau-Ponty, and more recent phenomenologists], and building a relationship of epistemic peers between physicians and pregnant women can help to confront epistemic injustice in pregnancy” (Freeman, 2015, 47) with the goal of pregnant women and physicians becoming what Freeman calls “epistemic peers” (Freeman, 2015, 46). This occurs when the physician exerts epistemic authority in conjunction with acknowledgement of the pregnant woman’s epistemic privilege.

Epistemic authority, Freeman (2015) correctly underscores, is intrinsically paternalistic in that it asserts a scientifically and clinically superior perspective on the health-related interests of pregnant and all other patients—fetal, neonatal, pediatric, and adult alike. One advantage of the concept of medicine as a profession as a hypothetical imperative is that it supports modesty about claims to epistemic authority: such claims are always limited, if only by the strength of the evidence for them. Too, the health-related interests of patients are, as Engel (1960) pointed out decades ago, biopsychosocial by their very nature. As a rule, physicians and other healthcare professionals can justifiably claim epistemic authority for biomedical clinical judgments. That authority rapidly diminishes when one includes psychological and social health, about which patients may indeed claim epistemic privilege.
V. PLACEbos

Two papers take up the ethical dimensions of placebos. Anne Barnhill and Franklin Miller provide a critique of a paper by Schlomo Cohen and Haim Shapiro that appeared in the *Journal* in 2013. Barnhill and Franklin argue that the use of placebos in almost all cases involves deception of the patient. It may not be a lie—representing as true what one knows to be false—to tell a patient that a “treatment” will help the patient. Notwithstanding, “the doctor’s sincere statement intentionally misleads the patient about the treatment (e.g., making him conclude it is a drug, not a placebo) and is therefore deceptive” (Barnhill and Miller, 2015, 74). Deception, they add, should be understood as “saying something vague but true with the intention to mislead” (Barnhill and Miller, 2015, 74).

Pugh (2015) goes against the grain in a striking way (always a good thing to do), advancing an argument that deception in one of its senses is compatible with respect for the patient’s autonomy. When a placebo is used under this conception, such use is not disrespectful of the patient’s autonomy. Pugh provides a succinct account of the placebo effect: “Although the exact mechanism underlying the placebo effect is widely debated, a considerable amount of evidence suggests that in order for placebos to be fully effective, the patient must have some expectation that the treatment being received will benefit him” (Pugh, 2015, 86). Such deception is, it seems, intrinsic to placebo use, which on its face seems not to be compatible with the requirement of honest communication with patients, which rules out deception, grounded in respect for autonomy. Pugh clarifies how he is using ‘autonomy:” “the autonomous agent is one whose will is not subjugated to determining forces of the sort that may be deemed to undermine his ability to direct his own conduct” (Pugh, 2015, 89). Influencing a patient to accept a false belief and doing so to subject the patient to the physician’s ends rather than the patient’s are both forms of deception that are not compatible with respect for autonomy. By contrast, “deceptions that are intended to facilitate the deceived agent’s pursuit of her own autonomously chosen ends” (Pugh, 2015, 93) are compatible with respect for the patient’s autonomy.

On my reading of it, the paper by Barnhill and Miller makes an implicit appeal to the concept of medicine as a profession. The intention to mislead is an intention that it is impermissible for physicians to have, I suggest, because such an intention is incompatible with intellectual integrity in medicine. Deception, especially a practice of deception, undermines the commitment to scientific and clinical competence. Pugh makes an explicit appeal to the concept of medicine as a profession and this appeal, on my reading, generates the requirement that deception, to be ethically permissible, must focus on the patient’s health and ends and not the physician’s chosen ends, that is, self-interest. This invokes the second component of the ethical concept of medicine as a profession. Impermissible deception undermines the
sustained commitment to intellectual and moral excellence that, in turn, sustains the hypothetical imperative of medicine as a profession.

VI. ETHICALLY SIGNIFICANT MORAL DISTRESS

Thomas and McCullough (2015) complement the introduction of the concept of moral distress by Jameton (1984), which acknowledged moral origins but was taken by scholars and investigators to focus mainly on moral distress as a psychological phenomenon, with the introduction of the concept of ethically significant moral distress. They define this as “the judgment that one is not able, to different degrees, to act on one’s moral knowledge about what one ought to do in specific clinical circumstances because of impediments” (Thomas and McCullough, 2015, 104). They then provide a philosophical taxonomy of six categories for ethically significant moral distress: challenges to, threats to, and violations of professional integrity; and challenges to, threats to, and violations of individual integrity.

Their appeal to professional integrity explicitly invokes the concept of medicine as a profession. In their section on preventing ethically significant moral distress, they emphasize the role of healthcare organizations in creating challenges to, threats to, and violations of professional integrity. Implicit in this emphasis is the insight—that physicians’ commitments to intellectual and moral integrity cannot be expected to be sustained in the absence of a supportive organizational culture.

VII. CONCLUSION

The concept of medicine as a profession, if it were to be understood as a categorical imperative, would seem to be able to sustain itself. This is what creatures of reason do. Hypothetical imperatives, by sharp contrast, do not sustain themselves. They are sustained by the deep and abiding commitment of individuals, groups, and, crucially, organizations that care enough about them and about what our lives would be like without them. Medicine as a profession will be sustained by the deep and abiding commitments of individual physicians, professional associations, and, crucially, organizations from state medical boards to group practices, clinics, hospitals, and hospital systems that care enough about the intellectual and moral integrity of physicians and therefore the life and health of patients. To speak with William James ([1907] 1967), the profession of medicine as a hypothetical imperative is something that physicians, physician leaders, healthcare organizations, and health policy (McCullough, 2013) make true.
REFERENCES


